TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ikechukwu Obih J MD

Respondent Name
LM Insurance Co

MFDR Tracking Number
M4-17-1361-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $277.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 99204, office or other outpatient visit for the evaluation and management of a new patient, requires three key components: comprehensive history; comprehensive examination; and medical decision making of moderate complexity. Code 99204 was denied per Medicare guidelines and correct coding rules, as documentation does not support this level of service. HCPCS Code A4556, electrodes per pair, was denied as supplies are not separately payable per Medicare guidelines."

Response submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2016	99204, A4556	$277.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 263 – 150 – The code billed does not meet the level/description of the procedure performed/documented
   - M384 – Supplies and materials included in the procedure

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered on February 15, 2016 in the amount of $277.50.

   The insurance carrier denied disputed services with claim adjustment reason code X263 – 150 – "Payer deems the information submitted does not support the level of service."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The submitted code in dispute is 99204 – "Office or other outpatient visit for the evaluation and management of a new patient, which **requires these 3 key components**: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

Review of the submitted medical documentation with "Electromyography (EMG) Report," date February 15, 2016 finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of present illness: Location, severity, timing, quality, associated signs and symptoms = Extended Problem Focused Review of systems: Constitutional, musculoskeletal = Pertinent to problem Past medical, family, social history, areas: Past Medical History = Pertinent to Problem	No
Comprehensive Examination	Body Areas: Back, one extremity = Expanded problem focused	No
Moderate complexity medical decision making	Number of Diagnoses or Treatment options points = 3 Amount and/or Complexity of Data Reviewed = 2	No Straightforward

Forty-five minutes face to face with the patient/and or family	No documentation found to indicate face to face time	n/a

Based on the above, the carrier's denial X253 – 150 – "Payer deems the information submitted does not support the level of service" is supported.

The carrier denied code A4556 as M-384 – "Supplies and materials included in the procedure. Review of code A4556 – "Electrodes (e.g., apnea monitor), per pair" has a status code of "P" Bundled or excluded codes. Therefore, the carrier's denial is supported.

2. The Division finds per the applicable Medicare coding policy for the codes in dispute, no additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.